MISSOURI DEPARTMENT OF HEALTH
BUREAU OF SPECIAL HEALTH CARE NEEDS

PRIOR AUTHORIZATION REQUEST

SEE INSTRUCTIONS ON REVERSE SIDE.
PLEASE TYPE.

1. DCN

2. PARTICIPANT NAME (LAST, FIRST, MIDDLE)	3. BIRTHDAY	4. PHONE NUMBER
5. ADDRESS (STREET)		6. SERVICE REQUESTED
(CITY, STATE, ZIP)		7. COUNTY / 8. COST OF SERVICE(S)
9. INSURANCE COMPANY		**THERAPY REQUEST**
10. CO. ADDRESS		12. # OF SESSION(S) PER _____ (WEEK) OR _____ (MONTH).
11. POLICY NUMBER(S)		13. DURATION OF SESSION(S) IN _____ (MINUTES).

14. DETAILED DESCRIPTION OF SERVICES REQUESTED

SERVICES AUTHORIZED OUTLINE THE LIMITS OF BSHCN FINANCIAL RESPONSIBILITY. THEY MAY OR MAY NOT EXACTLY REFLECT THE PHYSICIAN'S ORDER.

15. SIGNATURE (OTHER THAN APPROVED PHYSICIAN, ATTACH SIGNED ORDER/ MEDICAL REPORT) ►	16. DATE	17. TYPED NAME

HEARING AID REQUEST ONLY

18. NAME OF PROVIDER OF SERVICE	23. NAME OF AUDIOLOGIST
19. ADDRESS	24. ADDRESS (STREET)
20. CITY STATE ZIP	25. CITY STATE ZIP
21. TELEPHONE NUMBER / 22. PROVIDER NUMBER	26. TELEPHONE NUMBER

NO COMPENSATION SHALL BE CHARGED OR ALLOWED BY THE VENDOR OTHER THAN COMPENSATION FIXED AND ALLOWED BY THIS DEPARTMENT.

BSHCN USE ONLY

☐ 27. APPROVED
☐ 28. PENDING
☐ 29. DENIED

30. COMMENTS

AUTHORIZED THERAPY

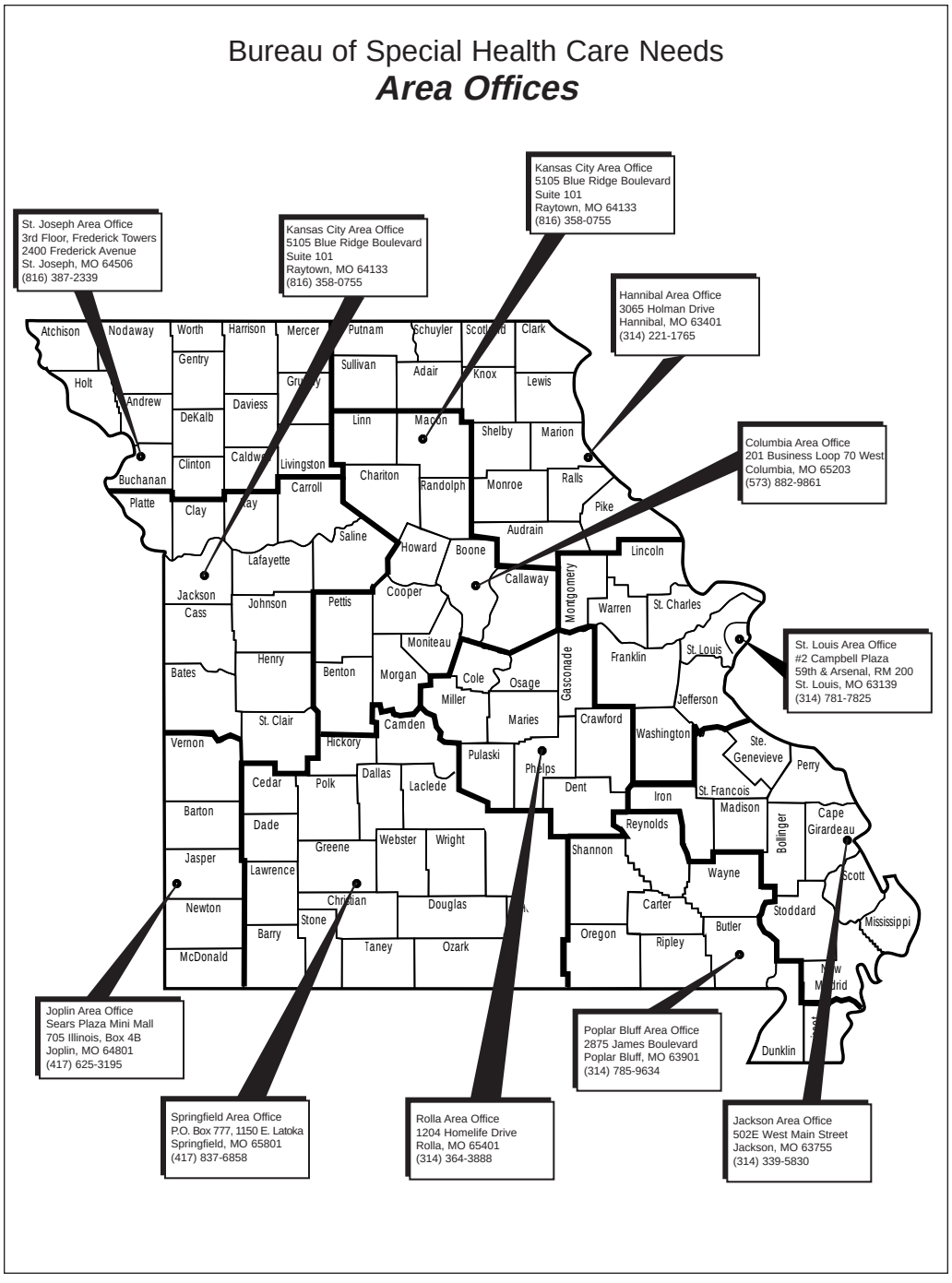
31. # OF SESSION(S) PER WK. OR MONTH	32. DURATION OF SESSION(S) IN MINUTES
33. EFFECTIVE DATE	34. EXPIRATION DATE
35. PROCESSED BY	36. DATE

PRIOR AUTHORIZATION REQUEST

FORM CC-9D

INSTRUCTIONS FOR COMPLETION
Form to be TYPED

1. Department Client Number.
2. Participant's name (last, first, middle).
3. Participant's date of birth.
4. Participant's telephone number.
5. Participant's address.
6. Service(s) requested.
7. Participant's county of residence.
8. Total cost of service(s) requested. (Must be within 10% of billed amount.)
9. Name of insurance company.
10. Address of insurance company.
11. Insurance policy number
12. Therapy-indicate of number of sessions per week or month.
13. Therapy-indicate duration of each session in minutes.
14. Detailed description of service(s) requested. Attach supporting documents as need. For equipment rental, indicate monthly rental cost and number of months needed.
15. Signature of Physician, Physical Therapist, Occupational Therapist, Speech Pathologist, Audiologist or authorized representative. If signature is other than Physician a signed order/medical report must be attached.
16. Date of signature.
17. Type name in located #15.
18. Name of provider of requested service(s).
19. Address of provider or requested service(s).
20. City, state, zip of the provider of service(s).
21. Telephone number of the provider of service(s).
22. Provider number.
23. Name of audiologist requesting hearing aid.
24. Address of audiologist.
25. City, state, zip of audiologist.
26. Telephone number of audiologist.



BSHCN USE ONLY (27 THROUGH 36 TO BE COMPLETED BY BSHCN PERSONNEL ONLY)

NO COMPENSATION SHALL BE CHARGED OR ALLOWED BY THE VENDOR OTHER THAN COMPENSATION FIXED AND ALLOWED BY THE DEPARTMENT.

Submit ORIGINAL TO BSHCN AREA OFFICE (Refer to above map).
Retain COPY FOR YOUR FILES.

TREATMENT CENTER and VENDOR WILL BE NOTIFIED IF REQUEST IS APPROVED or DENIED.